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ABSTRACT

Chapter 1 of this document defines school phobia as an exaggerated and irrational fear of attending school. In this chapter, school phobia is distinguished from truancy, the incidence and consequences of school phobia are discussed, characteristics of school phobia are described, and types of school phobia are identified. The chapter concludes with an estimation that school phobia is found in approximately two percent of the school population. Chapter 2 looks at the etiology of school phobia, reviewing psychoanalytic theories, psychodynamic theories, the families of school phobics, and biological factors. Chapter 3 focuses on the evaluation and identification of school phobia. The use of decision matrices is explained, a rationale is given for using matrices, and procedures for using decision matrices are described. Chapter 4 concentrates on intervention techniques, providing an overview of intervention research and looking at issues such as forced school attendance; rapid treatment; medication, hypnosis, and relaxation treatments; and parent involvement. Chapter 5 presents six case histories of children with school phobias. Chapter 6 discusses prevention of school phobia and offers recommendations for training and research. Warning signs of school phobia, a sample student data sheet, suggested resources, and a sample handout on school phobia are appended. A subject index concludes the document. (Contains 142 references.) (NB)

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THE IDENTIFICATION AND TREATMENT OF SCHOOL PHOBIA

Leslie Zeldin Paige

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The Identification and Treatment of School Phobia

Leslie Zeldin Paige
Hays West Central Kansas
Special Education Cooperative, Hays, Kansas

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

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8455 Colesville Road, Suite 1000
Silver Spring, Maryland 20910

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CHAPTER 1

INTRODUCTION

Every morning, Patty's screams preceded her entrance to school. Her mother would drag her up the sidewalk, detach her fingers one by one from the door jamb, and force her, step by step, to the third grade classroom. Her screams echoed down the hallway as the teacher blocked the doorway while Patty's mother left, sobbing.

Sam's kindergarten teacher felt that it was "simple separation anxiety," so she did not consult with the principal or school psychologist. Because his crying was upsetting the other students, Sam's mother was allowed to stay with him in the classroom. Staff in the teachers' lounge joked that his mother should receive a report card, as she had attended kindergarten full time for most of the year.

Much to the consternation of school officials, Martha had not attended school for 3 years. Her grandmother claimed that Martha was ill, but no one had been able to obtain confirmation from a doctor. Social welfare authorities were of little help because, technically, she was neither abused nor neglected.

School phobia has been discussed frequently since the 1930s, yet there has been little agreement regarding etiology or appropriate treatment. Because of the low incidence of this behavior, the experiential knowledge of many school practitioners may not be sufficient to meet the need for a rapidly initiated comprehensive treatment program. In an informal survey, school psychologists attending related workshops at conferences for the National Association of School Psychologists indicated that they had had little to no training in the identification or treatment of school phobia (Paige, 1989, 1991).

Although the etiology, dynamics, and treatment of school phobia have been described and discussed from different theoretical frameworks, adequate empirical investigations have been few (Knox, 1989; L.C. Miller, Barrett, & Hampe, 1974; Paige, 1989, 1991; Trueman, 1984a, 1984b). The scientific study of children's fears is undeveloped compared with adult phobia research (Barrios, Hartmann, & Shigetomi, 1981). There has been little agreement in the description and treatment of school phobia. When examining the literature, it is evident that clarification of the dynamics and recommendations for treatment are needed for the school practitioner.

School phobia has most often been defined as an exaggerated and irrational fear of attending school (Clyne, 1966; Kelly, 1973; Millman, Schaefer, & Cohen, 1981; Schaefer & Millman, 1980). A behavioral definition is that school phobia is an observable event of low frequency of school attendance (Ayllon, Smith, & Rogers, 1974). Broadwin (1932) was the first to describe the typical behaviors associated with school phobia, but A.M. Johnson, Falstein, Szunek, & Svendsen (1941) generally receive credit for coining the term *school phobia*. Other terms include school avoidance (Lambert, Weisz, Theisiger, 1989; Moss, 1986; Shaughnessy & Nystul, 1985), school refusal (Atkinson, Quarrington, & Cyr, 1985; Blagg & Yule, 1984; Bools, Foster, Brown, & Berg, 1990; Burke & Silverman, 1987; Last & Strauss, 1990), separation anxiety (Coolidge, Hahn, & Peck, 1957; Davidson, 1961; A.M. Johnson, 1957), acute school-induced anxiety (Knox, 1989), phobic disorder of school (Last, Francis, & Strauss,

Names have been changed to protect confidentiality.

1989), and retreat neurosis (Kasahara, 1989; see Table 1). Although criticized, most authors use "school phobia" as a term describing this set of behaviors (Shapiro & Jegede, 1973). For the purpose of this publication, school phobia will be used to describe a set of behaviors characterized by persistent absenteeism not due to actual illness or truancy.

School Phobia Versus Truancy

School phobia has been differentiated from truancy on the basis of four factors proposed by Gordon and Young (1976):

1. The truant is a poor student, whereas the school phobic was a good student previous to onset.
2. The truant avoids home, and the school phobic stays home.
3. Whereas the truant is absent intermittently, the school phobic is absent continuously for weeks or months.
4. The truant's parents are unaware of the absences, but the school phobic's parents are aware.

Want (1983a, 1983b) distinguished between truancy and school phobia, with the truant demonstrating antisocial or delinquent behaviors, poor academic achievement, and a lack of interest in school. The school phobic, however, may exhibit somatic complaints, anxiety, and distorted affect and tends to remain at home because of strong parental attachment.

Gittleman (1976) described the truant as being involved in antisocial acts, and enjoying freedom from school, unlike the school phobic, who remains at home and is anxious. *Truants* exhibit no conscious anxiety, dislike school, avoid both school and home, and feel little conflict about their avoidance (Coolidge, 1979). Fakouri and Jerse (1976) described six predictors of truancy, including notable changes in academic performance, persistent tardiness, long-term absenteeism, many school changes, marital problems in the home, and, interestingly, poor return of school health records (immunization records, medical physicals, etc.). Table 2 lists the major differences between truancy and school phobia.

Table 1

Other Terms Associated with School Phobia

School avoidance
Lambert, Weisz, and Theisiger, 1989
Moss, 1986
Shaughnessy and Nystul, 1985
L. Taylor and Adelman, 1990

School refusal
Atkinson, Quarrington, and Cyr, 1985
Blagg and Yule, 1984
Burke and Silverman, 1987
Last and Strauss, 1990
Bools, Foster, Brown, and Berg, 1990
Ficula, 1983

Separation anxiety
Coolidge, Hahn, and Peck, 1957
Davidson, 1961
A.M. Johnson, 1957

Acute school-induced anxiety
Knox, 1989

Phobic disorder of school
Last, Francis, and Strauss, 1989

Retreat neurosis
Kasahara, 1989

Incidence and Consequences of School Phobia

O'Brien (1982) stated that the primary reason for referral to child psychiatrists was school problems. School phobia is a prevalent problem among adolescents (Coolidge, Willer, Tessman, & Waldfogel, 1960) and young children. Mental health clinics report that school phobia is a frequent type of referral problem in children (O'Leary & Wilson, 1975). Estimates of incidence are mostly within the 1.7%–2% range (Kennedy, 1965; Millman, et al., 1981), and although it has been suggested that the percentage is increasing, there have been no supportive studies (Gordon & Young, 1976). Because school practitioners have difficulty distinguishing between school phobia and truancy, the exact incidence is not known (Want, 1983b).

Hersen (1972) questioned the information available on the duration and expected outcomes of school phobia due to the lack of longitudinal studies of untreated school phobics, although more recent studies have dem-

Table 2

Characteristics Differentiating Between Truancy and School Phobia

Want (1983a, 1983b)

Truant
- ☐ Chronic absenteeism
- ☐ Antisocial or delinquent behavior
- ☐ Little or no evidence of academic achievement or interest

School phobic
- ☐ Chronic absenteeism
- ☐ Somatic complaints
- ☐ Observable anxiety
- ☐ Distorted affect
- ☐ Strong attachment to parents
- ☐ Remains at home

Gordon and Young (1976)

Truant
- ☐ Poor student
- ☐ Avoids home when not at school
- ☐ Intermittent absences
- ☐ Parents unaware of absences

School phobic
- ☐ good student prior to onset
- ☐ Stays home when avoiding school
- ☐ Continuous, long-term absences
- ☐ Parents aware of absences

Coolidge (1979)

Truant
- ☐ Not anxious
- ☐ Avoids school and home
- ☐ Feels little conflict about absenteeism

Fakouri and Jerse (1976)

Truant
- ☐ Frequently tardy
- ☐ Has attended many different schools
- ☐ Observable change in academic performance
- ☐ School health records not returned to school
- ☐ Chronic absenteeism
- ☐ Marital problems of parents

Gittleman (1976)

Truant
- ☐ Antisocial behavior
- ☐ Enjoys missing school

School phobic
- ☐ Remains at home
- ☐ Highly anxious

onstrated a poor prognosis for children with school phobia. School phobia may result in unusually high rates of psychiatric disorders (Berg, 1982; Berg & Jackson, 1985), multiple phobias (Brulle, McIntyre, & Mills, 1985; McDonald & Shepard, 1976), work and college avoidance (Moss, 1986), delayed learning (Brulle et al., 1985), suicide (Oahara, 1987; Shaughnessy & Nystul, 1985), academic deterioration, inability to establish meaningful peer relationships, school or legal conflicts (McDonald & Shepard, 1976), panic attacks and agoraphobia (Casat, 1988; Perugi, Deltito, Soriani, & Musetti, 1988), and adult mood disorders (Adams, 1979).

Mary, age 25, explained that as a child, she had experienced difficulty returning to school following a lengthy absence because of flu. While home, she had received parental attention and toys and had been allowed to watch TV. When she returned to school, she was behind in her work, and she began to feign illness in order to stay at home. Aware that she was enjoying not sharing her mother with siblings and feeling socially inadequate with her peers, she began to artificially warm up the fever thermometer. When that became less effective, she began to induce vomiting, which "guaranteed a day off from school." Attempts to force school attendance resulted in tears, vomiting, and promises to attend "next week." Mary's mother arranged for homebound instruction and tutors. Mary attempted to attend college but is now severely agoraphobic, and suffers devastating bouts of depression and panic attacks. She has lived alone since her parents' deaths, and depends on her siblings for groceries and socialization. The house needs to be sold, but no one knows what to do with Mary.

The Japanese have shown considerable interest in school phobia (Kasahara, 1989; Makihara, Nagaya, & Nakajima, 1985; Shimizu, 1989; Takagi, 1984; Tatara, 1987; Wakabayashi, 1982; Yamamoto, 1987; Yunokawa, Hirati, Maki, & Shumizu, 1984). School phobia has been studied in many countries, including

France (Quere, 1984), England (Berg & Jackson, 1985), Venezuela (Granell de Aldaz, Vivas, Gelfand, & Feldman, 1984), Jamaica (Lambert et al., 1989), Australia (Renouf, 1985), Poland (Mattejat, 1981), and India (Rangaswami, 1983). This diverse representation would appear to indicate that school phobia is not a culture-specific phenomenon.

Characteristics of School Phobia

The characteristics of the school phobic have been investigated, and little agreement has been generated. Demographic studies reflect an even distribution of sex (Clyne, 1966; Kelly, 1973; Waldfogel, Tessman, & Hahn, 1959), but there is little agreement regarding the distribution of age (Heath, 1985; Talbot, 1957), or IQ (Boyd, 1980; Gordon & Young, 1976; Hampe, Miller, Barrett, & Nobel, 1973). Socioeconomic status appears to vary (Heath, 1985), there is no significant difference between birth position (Gordon & Young, 1976), and the age of onset appears to peak between 6 and 10 years of age (Kent, 1977; Millman et al., 1981; Milt, 1980). The school phobic is generally successful academically prior to onset (Gordon & Young, 1976; Quere, 1984).

There is much agreement that somatic complaints are common (Bowlby, 1973; Clyne, 1966; Coolidge, 1979; Greene & Thompson, 1984; Heath, 1985; Milt, 1980; Schaefer & Millman, 1980). Once school has been successfully avoided, the somatic complaints typically vanish (Clyne, 1966; Coolidge, 1979; Schaefer & Millman, 1980). The somatic component is thought to develop because *illness is a legitimate excuse for absence*. The younger child will play with friends after being absent from school and apparently feels no shame, but the older child's feelings of embarrassment or fear of social recrimination results in a generalized withdrawal. The adolescent tends to exhibit defiance and rationalization (Coolidge, 1979).

The school phobic has been described as being dependent, anxious, and immature (Trueman, 1984b). Levanthal and Sills (1964) viewed the school phobic as possessing considerable power and control at home, but Gordon and Young (1976) could not discern whether the school phobic is assertive and strong-willed or shy and timid. Want (1983a) listed five predominant personality features of the school phobic:

1. Anxiety
2. Willfulness toward parents
3. Depression
4. Dependency on parents
5. Unrealistic self-image

In his literature review, Heath (1985) found no consensus regarding the personality of the school phobic. This lack of agreement merely points out the critical need for a multidimensional procedure for evaluating the behaviors of the school phobic (Heath, 1985). Several authors have called for the investigation of the heterogeneity of school phobic behavior (Atkinson et al., 1985; Kearney & Silverman, 1990). Ficula (1983) regarded school phobia as being a multifaceted socioemotional "problem complex" associated with factors such as external locus of control, mood disturbances, family and peer problems, somatic complaints, and immature emotional outbursts.

Types of School Phobia

Efforts have been made to categorize distinct subclasses of school phobia. Kennedy (1965) felt that age was the critical factor for diagnosis and prognosis. Type I was thought to be most common in younger children from well-functioning families, and Type II was prevalent in older children. Kennedy believed that Type I is evoked by recent school-related events, whereas Type II is chronic and part of a pattern of generalized anxiety. Kennedy's diagnostic criteria were that if 7 of 10 of the following characteristics were present, the diagnosis was Type I, and if less than 7, then Type II was diagnosed:

1. Current episode is the first occurrence.
2. Following an illness on Thursday or Friday, onset occurs on a Monday.
3. Onset is acute.
4. It is most prevalent in the lower grades.
5. Child has expressed worry about death.
6. Mother is ill or child believes so.
7. Parents communicate well between themselves.
8. Parents are fairly well adjusted.
9. Father and mother share household management.

10 Parents are able to easily understand the dynamics involved in school phobia.

Marine (1968) described four distinct categories of school phobia:

1. Simple separation anxiety—not uncommon in the very young child.
2. Mild acute school refusal—similar to Kennedy's Type I.
3. Severe chronic school refusal—similar to Kennedy's Type II.
4. Childhood psychosis with school refusal symptoms are rare and part of a chronic and pervasive psychopathology that includes other symptoms.

L. Taylor and Adelman (1990) split school phobia into two types—proactive and reactive—that are further broken down into five subtypes distinguished by different motivations for avoiding school because of differences in self-determination, relatedness, and feelings of competence.

Sperling (1967) differentiated between common and induced school phobia. Common school phobia may be acute or chronic and is caused by a trauma that is considered a traumatic neurosis. Induced school phobia is caused by a pathological relationship with a parent who is disturbed. Coolidge et al. (1957) described two types: neurotic (younger children with acute onset who are able to function outside of the school environment) and characterological (gradual onset in early adolescence associated with generalized disturbed functioning). School phobia has also been differentiated as acute (preceded by at least 3 years of no difficulty) and chronic (all others; Nichols & Berg, 1970). In 1974, Sperling redefined acute school phobia as a loss of control and fear of death and induced school phobia as lacking an obvious precipitating event.

Atkinson et al. (1985) described three subtypes of school phobia:

1. Separation fears from being dependent on overprotective mothers.
2. Perfectionistic, depressed, and dominated by a childhood-deprived mother.
3. Fearful, depressed, and severely disturbed child from a dysfunctional family who has experienced separation or loss.

SUMMARY

Although called by many names, school phobia is considered to be a set of behaviors characterized by persistent absenteeism not due to truancy or an actual illness. It is found in approximately 2% of the school population, although this figure may be artificially low because of underreporting or misdiagnosis.

The literature is contradictory regarding the characteristics of school phobia, but it is clearly a distressing problem that can have a negative and lasting impact on the child. Although considered to be a low-incidence disorder, school phobia has been reported in many countries, and is receiving much interest in Japan.

Behaviors have been described that differentiate between the school phobic and the truant, notably observable anxiety, quality of academic performance, degree of contact with the parents, and patterns of absences. Another identifying characteristic includes the existence of somatic complaints. However, there is little agreement in the literature regarding the characteristics of the "typical" school phobic. Recent research calls for multidimensional evaluation efforts for a behavior that many now consider to be heterogeneous and multifaceted.

CHAPTER 2

ETIOLOGY OF SCHOOL PHOBIA

Mrs. B. walked Sara, a fourth grader, to her classroom every morning, despite living in close proximity to the school in a very small town. Sad farewells were made at the door, with both mother and daughter weeping and hugging. Sara began to refuse to come to school and, if at school, would cry and even flee the building to return home. The school intervention team requested that Mr. B. bring Sara. Separations were relatively easier, until Mrs. B. began to "drop by" to "check on Sara," resulting in even more crying and refusal to remain in school. The school intervention team banned Mrs. B. from entering school property until the exact dismissal time. Mrs. B. could thereafter be found all day in her car, parked in sight of the classroom, even when the outside temperature was more than 100°.

John was a 12-year-old sixth grader who had averaged 20 absences each year since kindergarten. He missed 11 days of the first month of school, all absences excused by his mother because of illness. The family background included many major traumas, including the death of John's father following years of cancer, as well as more recent deaths of grandparents and an uncle. His mother had resigned from her much-needed job because it made John "upset" when she went to work.

Psychoanalytic Theories

There have been many attempts to explain the acquisition of school phobic behavior. Psychoanalytic explanations tend to stress patterns of mildly neurotic mothers with unresolved dependency needs who cause the development of over-dependency in the child, which elicits a fear of separation and mutual repressed hostility. The separation anxiety is then displaced onto the school (Bakwin & Bakwin, 1972; Coolidge, 1979; Coolidge, Tessman, Waldfogel, & Willer, 1962; Kelly, 1973; Lassers, Nordan, & Bladholm, 1973; Smith & Sharpe, 1970). The separation anxiety may be linked to a fear of no longer being loved (Kent, 1977) or of death of the mother and therefore the child (Sperling, 1961). Some authors question whether school phobia should be considered not a phobia but a type of separation anxiety (A.M. Johnson, 1957; Milt, 1980).

Other explanations have described school phobia as a fixation at the oral-sadistic stage of development with narcissism, magical thinking, and ambivalence (Sperling, 1967, 1974). Adams (1979) viewed school phobia as a "prototypic childhood neurotic cluster" caused by a mother who communicates fears of separation with overtones of depression, sadomasochism, and bisexuality.

Psychodynamic Theories

Psychodynamic theories abound. Leventhal and Sills (1964) felt that the school phobic has an unrealistic self-image that results in an overvaluation of self and achievements. Staying at home enables the child to escape anxiety.

Coolidge (1979) hypothesized that school phobia occurs in families who have progressed socioeconomically higher than the grandparents. The parents feel isolated from their childhood culture and feel guilt about "abandoning" the grandparents. Because of fears of similar abandonment, the parents therefore tend to be overinvolved with their children.

Miller et al. (1974) believed that childhood phobias typically emphasize fears of physical injury, natural events, or social anxiety, with school phobia being within the latter category. Fear of something or someone within the school environment has also been proposed

(Coolidge, 1979; Kelly, 1973; Schaefer & Millman, 1980). Heath (1985) and Smith and Sharpe (1970) felt that school phobia is an expression of separation anxiety in younger children but is a fear specific to school in older children. Lazarus, Davison, and Polefka (1965) thought that school phobia is an avoidance behavior motivated either by an intense fear of the school environment or school social pressures. Yunokawa et al. (1984) described a case in Japan in which a 14-year-old girl became school phobic following peer-group rejection. Interpersonal problems at school were cited as the precipitating factor in another Japanese study (Makihara et al., 1985). Other Japanese studies have focused on Japan's emphasis on achievement and competition (Shimizu, 1989; Yamamoto, 1987), sociocultural factors (Tatara, 1987), one-parent families and interpersonal problems (Makihara et al., 1985).

Separation anxiety may therefore be the critical component for younger children, but older children may perceive the world (school) as more threatening (Heath, 1985). It is also thought that a significant event can precipitate the onset of school phobia, such as a new sibling, change of residence, or disease (Coolidge, 1979; A.M. Johnson et al., 1941).

Separation anxiety is also seen as being a learned behavior. Veltkamp (1975) felt that school phobia develops when separation anxiety is reinforced. The child who fears separation manipulates significant adults in order to avoid school. Lassers et al. (1973) felt that the child's fears that harm will befall family members while he or she is at school are reinforced by nonverbal cues from the family. McDonald and Shepard (1976) agreed that the primary fear is not of school but of separation from the family. The mother threatens to reject or abandon the child, who then associates going to school with loss of the mother. Staying at home is reinforced by pleasurable activities and maternal attention. Similarly, Garvey and Hegreves (1966) felt that the child becomes verbally conditioned to equate going to school with loss of the mother. School becomes a conditioned stimulus producing the conditioned response of fear. Staying at home is reinforcing in that it reduces fear and provides rewards in the form of toys, TV, and affection. Barrios et al. (1981) agreed that school phobias are primarily maintained by parent-initiated reinforcement rather than school-specific fears.

Doleys and Williams (1977) used attribution theory in order to explain school phobia. School acquires negative attributes in that the child sees it as a form of punishment. Academic failure and verbal or physical abuse are aversive, as is the interruption of positive reinforcers located at home. As a result, the child avoids school.

Families of School Phobics

Ryan had experienced several school phobic episodes over the years, particularly when making the transition from elementary to middle school, and now at the beginning of high school. His mother, a widow, had recently remarried. Her husband explained that he knew nothing about raising children, felt that his marriage was shaky because of conflicts regarding Ryan, and he complained about his father-in-law's interference. Ryan's mother always had an excuse for his absences, including mean teachers, mean classmates, "dyslexia," "seizures," and, currently, attention deficit disorder. None of these conditions were ever verified, despite numerous medical tests, conferences, evaluations, and professional observations. While at home, Ryan enjoyed TV, snacks, and visits from his grandfather. The grandfather complained that the boy was being "ruined," which justified his interference. Testing indicated academic achievement at the 80th percentile or above. Ryan's mother withdrew him from school and began a home schooling program.

School phobia as a learned pattern of behavior within family systems has been described in case studies of multiphobic families (Sherman & Formanek, 1985). Coolidge (1979) felt that school phobic families are unable to communicate individual needs and that there is an overinvolved extended family.

Family systems theorists have advanced theories regarding the influence of family interaction patterns. Bowlby (1973) described four patterns of family interaction that cause school phobia:

1. The mother keeps the child home as a companion because of her attachment anxiety.
2. The child stays at home to prevent something negative from happening to the parents.
3. The child remains at home to prevent something negative from happening to himself or herself while away from home.
4. The parent keeps the child at home to prevent something negative happening to the child.

In addition, the fear of being separated from home and family may be related to family conflicts (Bowlby, 1973; Kent, 1977).

Renouf (1985) described the typical school phobic as originating from a large family with overinvolvement of several generations and poor sibling subsystems. Loof (1979) found an increased incidence (10 times higher than urban data) of school phobia in Southern Appalachia. He theorized that the family structures and values accounted for the higher number of referrals because of the strong family orientation. The interdependent and inner-directed families resulted in separation anxiety being a major emotional conflict.

School phobia has been attributed to families who have maladaptive communication patterns (Hickie & Silove, 1989), significant family dysfunction (Bernstein & Garfinkel, 1988; Bernstein, Svingen, & Garfinkel, 1990), specific familial interaction patterns (Huffington & Sevitt, 1989), and family violence (Mihara & Ichikawa, 1986).

The characteristics of the school phobic and his or her family have been investigated but with little agreement (Gordon & Young, 1976; Heath, 1985; Trueman, 1984b).

Biological Factors

Some biological explanations of school phobia have been offered. Chiba (1984) proposed that it may be caused by desynchronized circadian rhythms, but there have been no corroborating studies. School phobic behavior has been associated with other medical conditions, such as Tourette's syndrome (Linet, 1985; Plapp, 1990), cerebral tumor (Blackman & Wheler, 1987), mitral valve prolapse (Casat, Ross, Scardina, & Sarno, 1987), and Heller's Syndrome (Kurita, 1988).

SUMMARY

To summarize, school phobia is a much-described but poorly understood behavior. Behaviorally defined, school phobia is an observable event of low frequency of school attendance (Ayllon et al., 1974). School phobia has also been popularly defined as an irrational fear of school. Somatic complaints are usually seen as an integral component that seems to serve the function of manipulating adults in order to avoid school.

There is much disagreement as to the demographic or personality characteristics of the "typical" school phobic. Some researchers feel that school phobia is qualitatively and etiologically different in childhood versus adolescence (Coolidge et al., 1957; Heath, 1985; Kennedy, 1965; Marine, 1968; Smith & Sharpe, 1970). There is a lack of consensus as to whether the child's fears are school specific (Coolidge, 1979; Kelly, 1973; Lazarus et al., 1965; Makihara et al., 1985; Smith & Sharpe, 1970; Schaefer & Millman, 1980; Yunokawa et al., 1984) or due to neurotic mothers and other psychoanalytic explanations.

Some researchers feel that school phobia arises in a manner different from other phobias (Kent, 1977), whereas others feel that it is not a phobia but a form of separation anxiety (McDonald & Shepard, 1976; Milt, 1980; Veltkamp, 1975). However, it is apparent that the behaviors exhibited by school phobics do frequently seem to function for the purposes of fear reduction and attainment of positive reinforcers available at home.

CHAPTER 3

EVALUATION AND IDENTIFICATION OF SCHOOL PHOBIA

Evaluation

There has been relatively little written regarding the evaluation of school phobia. Table 3 lists guidelines developed by DiBacco (1979).

DiBacco felt that school phobia needs to be considered in a multifaceted manner, including a description of the behaviors and an examination of the factors relating to the child, family, and the school.

As seen in Table 4, additional suggestions were provided by Berry and Lizardi (1985) in their guidelines for the identification of school phobic children. They looked at "indicators" within the behaviors exhibited at school, personal behaviors, and family characteristics.

Ollendick (1983) used the Revised Fear Survey Schedule for Children and found that it

Table 3

DiBacco's (1979) Evaluation Guidelines for School Phobia

I. Problem description
- A. History and onset
- B. Duration
- C. Intensity
- D. Levels of stress at school and home

II. Child evaluation
- A. Physical history
- B. Psychological history (significant events such as separation and losses)
- C. Present coping style (school and home)
- D. Present learning status
- E. Significant attachments

III. Family system
- A. Attachment figures
- B. Number of parents in the home
- C. Stability
  - 1. Relationships (parent-parent, child-parent)
- D. Communication patterns
  - 1. Current adequacy
  - 2. Clarity
- E. Problem-solving style
- F. Use of threats to control
- G. Life events
  - 1. Parents
  - 2. Family
- H. History of adjustment difficulties
- I. Major barriers and alliances in existence
- J. Syntonicity or dystonocity of child's behavior

IV. School environment
- A. Significant attachment figures
  - 1. Adults
  - 2. Children
- B. Fear-evoking stimulus/stimuli
  - 1. Primary
  - 2. Secondary
- C. Cooperation
- D. Flexibility
- E. Resiliency

Table 4

Guidelines for the Identification of School Phobia: Berry and Lizardi (1985)

I. School behavior and indicators
- A. Increased excused absences and tardies
- B. Passivity, withdrawal, shyness, fears to participate in group activities
- C. Increased fighting, attention seeking, crying
- D. Anxiety regarding missed schoolwork
- E. Frequent requests to leave class
- F. Changed responses toward school responsibilities
- G. Observable pattern of absences
- H. Unexplained fear of school events
- I. Continuous or extended absences

II. Personal behavior indicators
- A. Anxious behaviors apparent
- B. Frequent somatic complaints
- C. Personal history of physical illness
- D. Depressive symptoms
- E. Behaviors indicating inferiority feelings
- F. Perfectionistic tendencies
- G. Highly self-critical

III. Parent and family indicators
- A. Parents not involved in school activities
- B. Observable separation-anxiety-related behaviors
- C. Unusual attachment to mother
- D. Absences related to traumatic home situation or recent change in home environment
- E. Father overly absorbed with work
- F. Mother overly protective and fosters continued dependency
- G. Child is in close contact with parent when absent from school
- H. Parents experiencing communication problems with each other

was able to discriminate between a sample of normal students and school phobics. However, further research is needed on the utility of these data.

Heath (1985) recommended that the evaluation of school phobia must consider the child, the school, and the family. The decision matrices and guidelines described in this book were developed in order to assist in the identification and treatment of school phobic children within the family and school environments.

Identification of School Phobia

When attempting to diagnose school phobia, it is essential that an immediate diagnosis be made so that a comprehensive treatment program may be planned and implemented, using a coordinated team approach. Schools should not wait for outside agencies or nonschool professionals to diagnose and develop interventions because of the resulting delay in treatment (Want, 1983b). The role of the teacher is very important, and significant school staff members must be involved (Gittleman, 1976). In order to facilitate accurate diagnosis, several decision matrices and guidelines have been developed as a helpful tool for school psychologists and other professionals likely to be involved in the treatment of school phobia.

Figure 1

Using the Decision Matrices

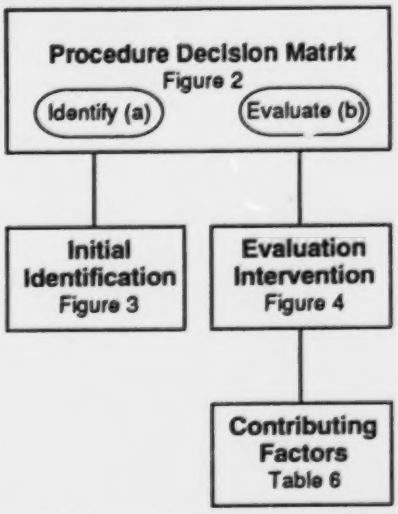


Table 5

Foundations for the Decision Matrices and Treatment Guidelines

I. Theoretical basis
   A. Etiology
   B. Treatment
II. Environmental influences
   A. School
   B. Community
   C. Home
III. Family influences
   A. Parents
   B. Siblings
IV. Internal factors
   A. Age of child
   B. Health of child
   C. Recent history
      1. Trauma
      2. Stress
V. Team member involvement
   A. Team membership
      1. School psychologist
      2. Principal
      3. Teachers
      4. Parents
      5. Social worker
      6. Physician
      7. School nurse
      8. Others
   B. Need for agreement regarding conceptualization of school phobia
   C. Need for collaboration in treatment planning and implementation
VI. Other considerations
   A. Need for rapid treatment
   B. Forcible school attendance considerations
VII. Intervention
   A. Planning
   B. Training of team
   C. Monitoring
VIII. Evaluate effectiveness of treatment

Why Decision Matrices?

Several decision matrices were developed to be used by school professionals for the intervention and treatment of school phobia. Decision matrices are easy to understand and provide a framework and sequence for diagnosis and treatment. They have been field tested and were found to be extremely useful for managing school phobia team interventions (Paige, 1989, 1991). By providing practical guidelines, the treatment may be initiated rapidly, which is a critical factor in prognosis.

Using information gathered from available research, decision matrix and treatment guideline handouts were developed to address several foundations for treatment (see Table 5).

General Procedures for Using the Decision Matrices

The decision matrices are built on a basic process or procedure to be followed as a guide. As the school team follows the procedure decision matrix, the identify and evaluate problem step branches into two additional submatrices: initial identification and evaluation and intervention (see Figure 1). This was done for purposes of clarity and to enable the user to focus on important submatrices of the basic procedure decision matrix.

Additionally, the evaluation and intervention submatrices are further explained by the summary of contributing factors in the etiology and maintenance of school phobia shown in Table 6.

Table 6

Summary of Contributing Factors in the Etiology and Maintenance of School Phobia

MEDICAL
- Chronic or life-threatening illness of child or significant other
- Illness or medication that affects appearance or behavior
- Recent illness requiring long absence
- Physical or sensory deficits

SCHOOL RELATED
- Sadistic teacher or other adult at school
- Inappropriate educational placement
- Difficulty with or fear of specific school activity (i.e., oral reading, physical education, speaking in front of class, etc.)
- Physical threats or actions by others in school or on school route (i.e., mugging, shakedown, blackmail, child believes someone or something at school will cause harm)
- Noxious school environment (i.e., violence, poor time management, poor morale, poor allocation of resources, etc.)

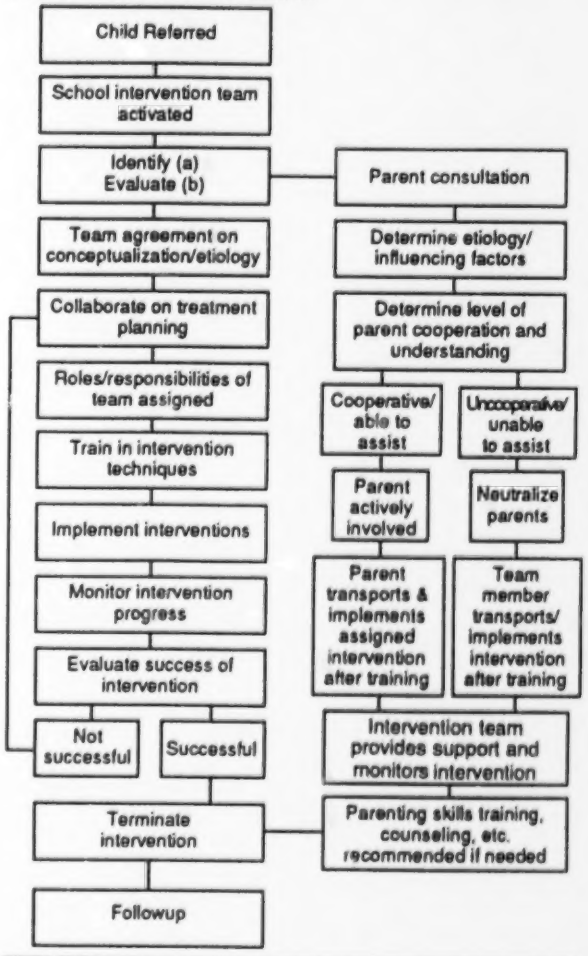
SOCIAL SKILLS DEFICITS
- Peer problems
- Teasing, being teased
- Fighting
- Coping style
- Being ignored
- Shy, withdrawn
- Language or cultural

PARENTS AND FAMILY
- Emotionally disturbed family member
- Maladaptive alliances
- Unstable home (i.e., financial, relationships, etc.)
- Poor communication
- Poor discipline or parenting
- High level of stress (i.e., illness, problems with sibling, finances, etc.)
- Familial expectations regarding academic performance
- Familial pattern of adjustment problems or phobias

RECENT EVENTS
- Relocation
- Death
- Divorce
- Experienced or witnessed traumatic event
- New sibling
- Illness
- Remarriage

Figure 2

Procedure Decision Matrix

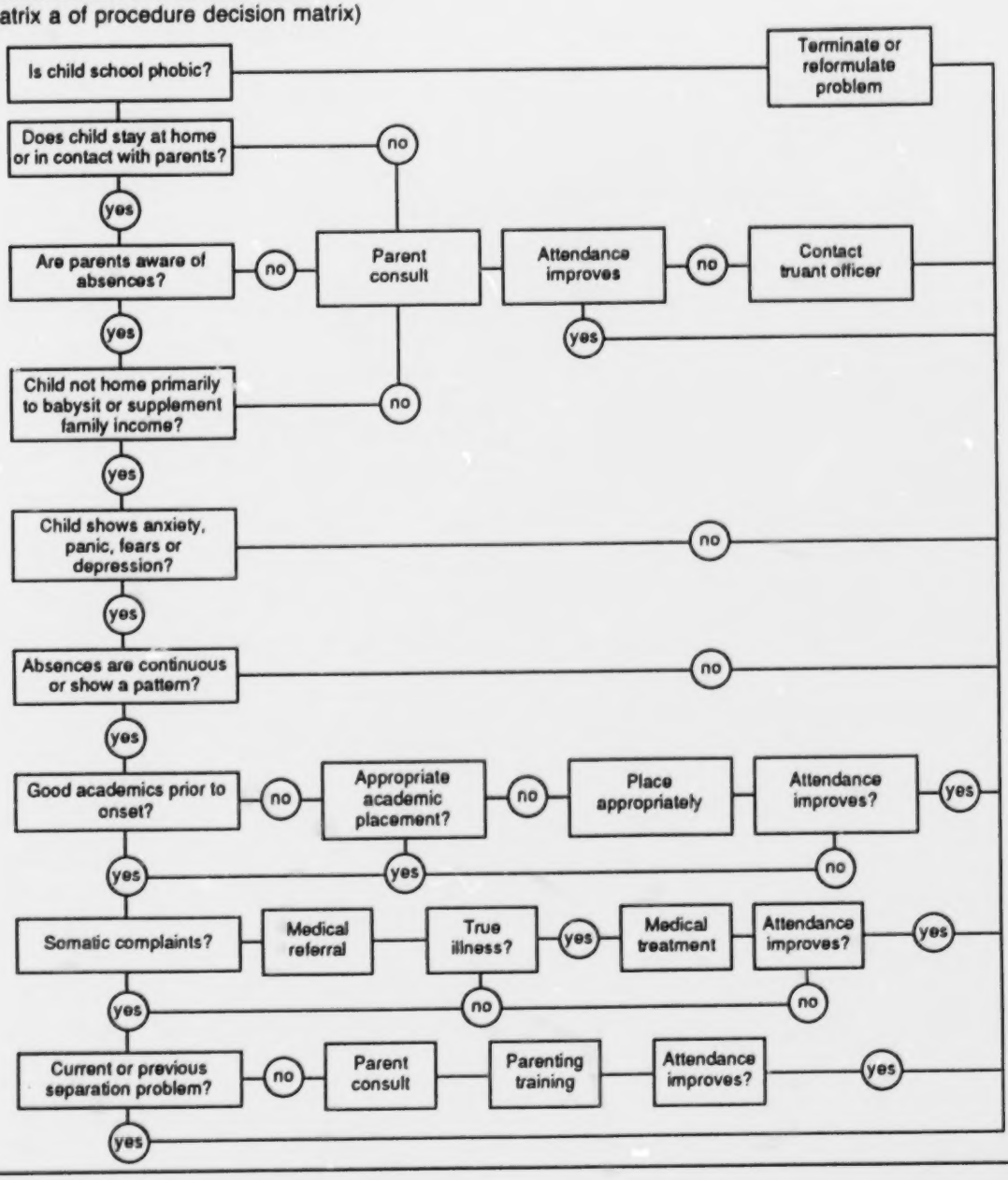


Using the Initial Identification Decision Matrix

Ideally, when a child exhibits chronic absenteeism, or if there is suspicion of school phobia, the teacher will notify the school attendance officer, school nurse, or principal. An initial decision needs to be made to refer the child to a team comprised of any or all of the following: school psychologist, school counselor, principal, teacher, school nurse, social worker, and teacher. Problems may arise if the teacher does not refer the child immediately because treatment delays decrease the likelihood of a good prognosis. Teachers may hesitate to refer a

Figure 3

Initial Indentification Decision Matrix
(Submatrix a of procedure decision matrix)



child for many reasons: previous experiences, knowledge of the child's background or family situation, needing to deal with more pressing classroom concerns, limited knowledge about school phobia, and other factors. In order to facilitate early referrals, it is recommended that school staff receive information on the warning signs of school phobia (see Appendix A).

When the referral question "Is this child school phobic?" is asked, the first step is to activate a school team. The task at this point is to decide if the child is school phobic. By using the decision matrix in Figure 3, the school team can determine diagnostic factors to differentiate between truancy, illness, and school phobia.

For example, when a child is referred for a problem primarily characterized by poor school

attendance, the school intervention team enters the procedure matrix (see Figure 2) at the "child-referred" step. The intervention team's first task is to diagnose school phobia. The team next refers to the initial identification matrix (see Figure 3) to determine whether the behaviors are school phobic, legitimate illness, inapp opriate academic placement, or truancy. Information is gathered from parents, teachers, and others who are working with the child (i.e., physicians, psychologists, etc.). Data must be multisourced and may be obtained through structured interviews, attendance and academic records, and readily available medical information. Appendix B contains examples that maybe copied and used. Because rapid treatment is important, it is recommended that the team consider information that is "on hand" or quickly obtained, unless medical factors are a real concern requiring *medical attention*. Obviously, a comprehensive, multidisciplinary evaluation would be time consuming and ill-advised at this point. However, data from a previous evaluation would be appropriate for consideration.

If school phobia is not diagnosed, the *initial identification decision matrix* (Figure 3) indicates appropriate courses of action, such as parent consultations, medical treatment, more appropriate academic placement, or following truancy procedures (truancy criteria and policies differ between districts and states).

Once school phobia is diagnosed, the team reenters the procedure matrix (see Figure 2). The next task is to determine the etiology of the behavior, as well as contributory factors. Agreement by the team regarding etiological issues is important for team compliance with the treatment plan. For example, each team member could maintain a different belief regarding the cause of the student's school phobia, and would react to the treatment plan in an inconsistent manner.

Interviews with the staff and family indicated a lack of agreement. The teacher believed Andy was "spoiled rotten," but the principal was convinced that the teacher was "scaring him" with her disciplinary tactics used on other children. The social worker focused on family systems problems, the mother blamed last year's teacher, and the school nurse felt that there was a real medical problem that was causing him to miss school. Meanwhile, no one had given instructions to the school secretary, who had given Andy considerable reinforcement for his somatic complaints, allowing him to lie down in the nurse's office and offering considerable sympathy. With these differing beliefs, the chances are very poor that this team will be able to develop, let alone implement, an effective intervention.

As part of the process of becoming an effective team, agreement regarding etiology is therefore very important. It is critical for the intervention team leader to forge a cooperative team that shares a similar philosophy and intent. There are many publications available regarding consultation, collaboration, and teaming within the schools (see Appendix C).

CHAPTER 4

INTERVENTION

Using the Evaluation and Intervention Decision Matrix

Once school phobia has been diagnosed and etiological factors agreed on, the school intervention team uses the evaluation and intervention decision matrix (see Figure 4) to select appropriate treatment. By referring to Table 6 (see chapter 3), the team can discuss whether the school phobic behaviors are primarily medical, school related, caused by social or family problems, or related to a recent loss.

Few cases of school phobia have only one causative factor. The most common scenario is for several problems to be occurring within the child, at home, and at school. Cases with multiple etiologies are difficult to prioritize which etiology-intervention path to choose for initial treatments. Obviously, if school phobic behaviors in a particular child are caused by several factors (i.e., poor social skills, recent trauma, family crisis, poor parenting,and an overly dependent parent-child relationship), then different treatments would be required (i.e., social skills training, conditioning, family counseling, parenting training, etc.). Just as obviously, it would be difficult to implement more than a limited number of treatment programs simultaneously. However, because the evaluation and intervention decision matrix does not rank order the etiologies or interventions, the intervention team is forced to analyze and weigh the importance of the different etiologies in the process of making treatment decisions. Therefore, each case is still approached in terms of its uniqueness, and the group processes necessary to determine the importance of various treatments may help to form a feeling of ownership with the treatment program. Although further research is needed, it could be further extrapolated that this feeling of group responsibility could engender a more cohesive and comprehensive implementation of the treatment rather than a totally "canned" program could instill. See the resources listed in Appendix C for more information on collaborative teams.

Once the primary problem has been agreed on, the team's next task is to determine an appropriate treatment. The evaluation and intervention decision matrix (see Figure 4) *provides* suggested treatments for the team to consider.

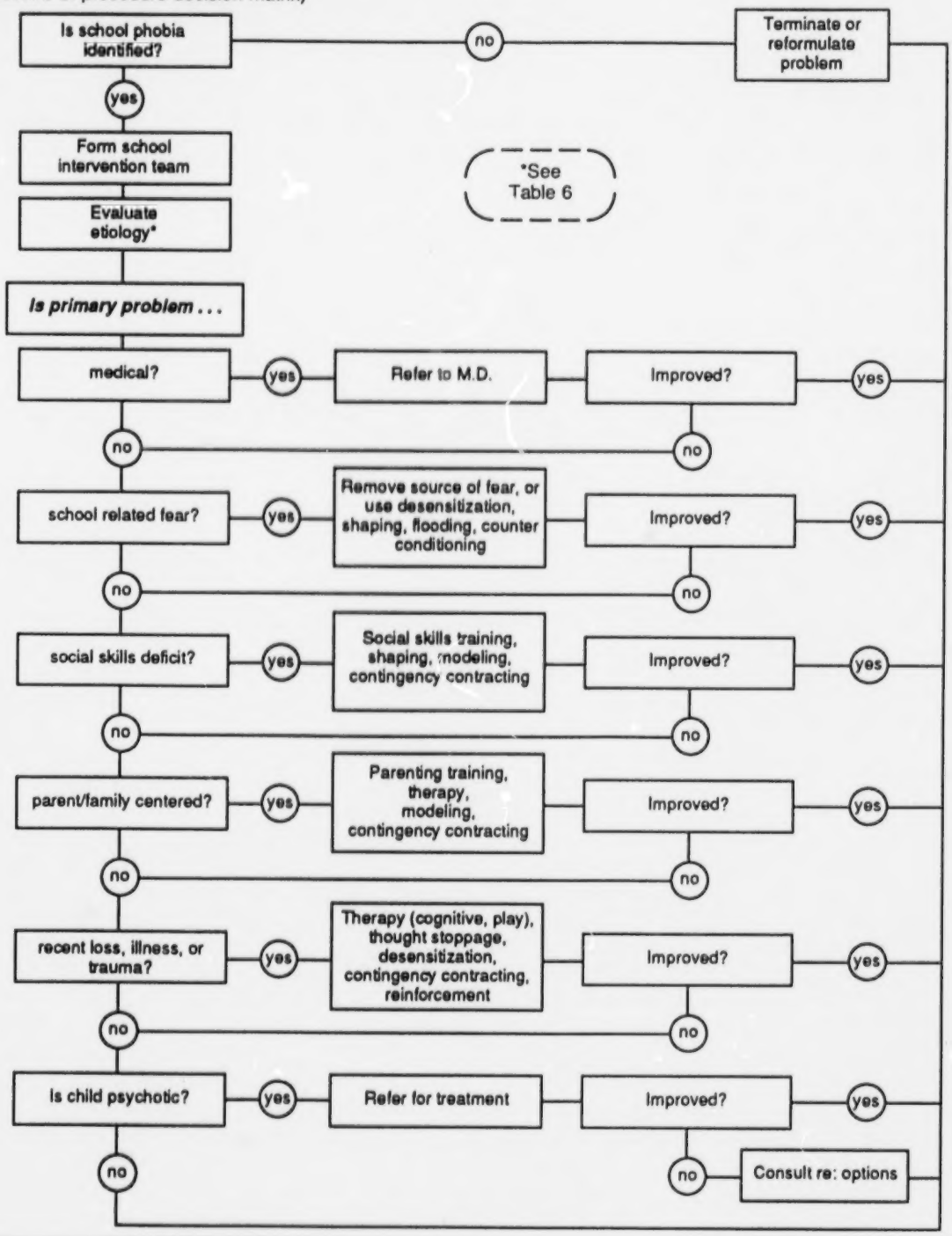
Overview of Intervention Research

The literature is contradictory regarding the efficacy of various intervention techniques for the treatment of school phobia (S.B. Johnson, 1979). Because of the lack of controlled treatment comparisons, it is difficult to determine the "best" treatment (Gelfand, 1978). Ferrari (1986) cautioned that using interventions based on adult models for fear-related conditions is inadequate because of the need to consider developmental aspects when working with children. In prior years, treatment of school phobia was psychoanalytically oriented. The goal of treatment was to resolve underlying neuroses as well as relieve symptoms (Kelly, 1973; Sperling, 1974). Klein (1945) used brief therapy with a rapid return to school followed by long-term treatment to modify the neurosis. Sperling (1974) sometimes treated the child by treating the parent psychoanalytically. Adolescents, however, were treated directly and a different therapist worked with the parent. School phobia has also been treated using controlled regression (Newman & Stern, 1964).

Three other major therapies have been used: psychodynamic, behavioral, and cognitive (Brulle et al., 1985). Kennedy (1965) reported a 100% cure rate in a program that targeted the strengthening of the child's sense of self in a reality-oriented manner (Kelly, 1973; Want, 1983a and 1983b). Kennedy outlined six critical factors:

Figure 4

Evaluation and Intervention Decision Matrix
(Submatrix b of procedure decision matrix)



1. In order to develop cooperation in identification and treatment, a good public relations program is needed.
2. Forcible school attendance.
3. Avoid emphasis on somatic complaints.
4. Provide structured parental interviews to support and encourage them when the child resists treatment.
5. Encourage the child to overcome fears.
6. Provide further parental support through follow-up procedures.

Lazarus et al. (1965) used classical conditioning techniques when the school phobia was caused by extreme anxiety and operant conditioning techniques if secondary reinforcers were to blame. In the classical conditioning situation, reinforcers were paired with the school to produce reciprocal inhibition. Rewards contingent on attendance constituted the operant conditioning treatment. Hersen (1968, 1970) focused on the operant aspects. Counter conditioning has also been used successfully (Patterson, 1965).

Institutionalization is rarely recommended. It was encouraged by Weiss and Cain (1964) for cases resisting other treatments available at that time. They felt that institutionalization increases the child's ability to understand his or her anxiety, removes the child from the pathological home situation, and provides "ego-supportive experiences." Quere (1984) felt that institutionalization is beneficial in that it interrupts the family's isolation and guilt patterns. Positive self-esteem is engendered through the development of transference within the institutional setting.

Table 7 illustrates five major types of behavioral therapies used to treat children's phobias, as summarized by Morris and Kratochwill (1985).

Behavioral treatments have been successfully used with school phobias (Ayllon et al., 1974; Cretekos, 1977; Doleys & Williams, 1977; Garvey & Hegreves, 1966; Gresham & Nagle, 1981; Kennedy, 1965; Klungness & Gredler, 1984; McDonald & Shepard, 1976; Prout & Harvey, 1978; Smith & Sharpe, 1970; Tahmasian & McReynolds, 1971; Taylor, 1972). Trueman's (1984a) literature review regarding behavioral treatment techniques for school phobia agrees that it is effective; however, there is a "blurring" of treatment techniques being used (i.e., desensitization would be used with assistance from classical or operant conditioning). He complained that the lack of clearly delineated treatments and nonstandardized criterion measures prohibited controlled comparative research.

Table 7

Types of Behavioral Treatments Used to Treat Children's Phobias: Morris and Kratochwill (1985)

I. Systematic desensitization
   A. Group systematic desensitization
   B. In vivo desensitization
   C. Automated systematic desensitization
   D. Emotive imagery
   E. Contact desensitization
   F. Self-control desensitization
II. Flooding
   A. Implosion
   B. Flooding
   C. In vivo flooding
III. Contingency management
   A. Positive reinforcement
   B. Shaping
   C. Stimulus fading
   D. Extinction
IV. Modeling
   A. Live modeling
   B. Symbolic modeling
V. Self-control

There has been little empirical study on the effectiveness of self-control or modeling as treatments for school phobias. The use of implosion has been cautioned against for ethical reasons (Graziano, 1975) and practical difficulties (Gelfand, 1978; Ullman & Krasner, 1975). Ullman and Krasner (1975) cautioned that for implosion to be successful, the therapist must possess considerable clinical skill so that the aversiveness of the treatment is associated with the treatment objectives. Gelfand (1978) also warned of the possibility of the child refusing to cooperate or even return because of the aversiveness of the treatment.

Contingency management (Ayllon, Smith, & Rogers, 1970; Brown, Copeland, & Hall, 1974; and Tahmasian & McReynolds, 1971), successive approximation (Suzuki, Kobayashi, & Sasaki, 1985), desensitization training (Garvey & Hegreves, 1966; Rangaswami, 1983), positive practice (Kolko, Ayllon, & Torrence, 1987), emotive imagery and in vivo desensitization (Houlihan & Jones, 1989; Lazarus et al., 1965) have also been used to treat school phobia with some success. Want (1983b) recommended that the most practical interventions that school

professionals can use are desensitization, contingency contracting, and team-based forced school attendance.

Behavioral treatments are emphasized because of their economy, reliability, objectivity, the effectiveness of the multidisciplinary emphasis, and the need for newly acquired behaviors to be stabilized (McDonald & Shepard, 1976). The selection of a particular method of treatment depends on the severity and nature of the problem. Because of differing or multiple etiologies, individualized intervention programs are necessary.

Blagg and Yule's (1984) comparison of behavioral therapy with psychotherapy demonstrated that a flexible behavior therapy approach that included family and school factors was more effective, faster, and less expensive. Mattejat (1981) cautioned that an essential treatment factor is the necessity to manage the family problems. Renouf (1985) also encouraged a shift in focus to the family. Hsia (1984) felt that strengthening the sibling's roles and recreating appropriate parent-child relationships were essential for treatment. Heath (1985) encouraged the use of significant others in implementing treatment procedures.

Forced School Attendance

There is some controversy regarding the use of forced school attendance as part of the treatment. It has been used in several successful treatments (Kelly, 1973; Kennedy, 1965; Rodriguez, Rodriguez, & Eisenberg, 1959). Want (1983b) reasoned that forcible attendance is essential because

1. Nonadaptive behaviors are reinforced by continuous absences.
2. Continuous absences lead to impaired social functioning and possible irreversible psychopathology.
3. The family may be unable to provide consistency, so school may be the primary stabilizing influence.
4. The child needs to recognize that the problem is at home, not at school.

However, there are several arguments against forcing the school phobic to return to school. Although Gelfand (1978) agreed that forcible attendance does prevent reinforcement of the avoidance behaviors, she felt that the resultant stress is unnecessary in comparison to positive reinforcement techniques. Smith and Shepard (1970) also felt that the techniques resulted in too much stress. Gelfand et al. (1974) proposed that this technique could accidentally teach the child through modeling to be callous and to ignore the feelings of others. Another difficulty occurs if the child is too large or is older, making it unsafe or physically impossible to force school attendance.

The team considered forced school attendance for Ryan, who would stay in bed and flatly refuse to attend school, complaining of various ills. The plan was rapidly abandoned because Ryan was, at age 14, approximately 5'8" and weighed 130 pounds. The football coach was initially interested in going to the home and "convincing" Ryan to go to school each morning, but he later declined, citing fear of legal or insurance complications.

Rapid Treatment

Universal agreement regarding the treatment of school phobia is restricted to a single proposition: Early treatment is the single most important predictor of a good prognosis (Adams, 1979; Coolidge et al., 1957; Goldenberg & Goldenberg, 1970; Kelly, 1973; Kennedy, 1965; McAnanly, 1986; McDonald & Shepard, 1976; Timberlake, 1984; Waldfogel, Tessman, & Hahn, 1959). King and Ollendick (1989) however, cautioned that the rapid or gradual return to school should be planned according to individual case differences. They warned that although some children need to be returned to school slowly, secondary negative effects can be minimized by a rapid return to school. There are some who feel that the type of treatment techniques used are not as important as the rapidity of treatment initiation (Adams, 1979; Coolidge et al., 1957).

Medication, Hypnosis, and Relaxation Treatment

The biological influences governing school phobia have been relatively ignored. Drugs

such as imipramine (Adams, 1979; Gittleman-Klein & Klein, 1971, 1973; Robiner & Klein, 1969), tofranil (Blau, 1978), and sodium pentothal (Nice, 1968) have been successfully used in combination with behavioral treatment. Although biological influences may not be entirely discounted (because of a lack of research), the drugs might have been most effective in terms of their qualities of inducing relaxation or reducing depression, which would enhance effectiveness of the behavioral treatment. Relaxation training and hypnotherapy have been used effectively (Cowell & Franklin, 1983; Keleman, 1988; Lind, 1987). Medication and hypnotic interventions are not typically available from school staff but may be helpful as an adjunct to school treatment plans on a selected basis for particularly resistant or extremely anxious children.

Other Critical Treatment Factors

There is agreement that the child's somatic complaints should be ignored if no medical basis has been found (Blanco, 1982; Kennedy, 1965; Tahmasian & McReynolds, 1971). Additionally, recent literature tends to emphasize the need to choose treatments based on the determination of the source of the fear (Atkinson et al., 1985; Gelfand, 1978), individualize specific therapies (Kearney & Silverman, 1990), and the need to involve parents and school personnel (Blanco, 1982; Doleys & Williams, 1977; Gresham & Nagle, 1981; Klungness & Gredler, 1984; Prout & Harvey, 1978; Tahmasian & McReynolds, 1971) in order to extinguish the maladaptive behaviors by removing potentially reinforcing consequences for avoiding school while making school more reinforcing. Interprofessional agreement regarding the conceptualization of school phobia and its treatment is essential because of the number of different professionals possibly involved in a single case (i.e., physician, psychiatrist, school psychologist, school counselor, principal, teacher, social worker, etc.). Without this agreement and cooperation, effective treatment may be hampered (Greene & Thompson, 1984; Will & Baird, 1984).

The school principal contacted a local mental health clinic for assistance. The clinical psychologist came to the school to explain his treatment plan. The plan called for the child being taken to the special education classroom at the beginning of the day (She had not been evaluated nor did she have an individualized education program [IEP]). He decided to use the special education class as an "aversive" and told the staff that Patty would need to earn placement back into her classroom through a five-step program of "gradual successive approximations combined with maternal separation desensitization." Patty's "good behavior" in special education each morning would result in her being gradually moved closer to the regular classroom, with her mother's proximity being decreased until Patty could sit in her regular classroom without her mother. There was a complex system of points and tokens for reinforcers at school and at home. On paper, the program was a showcase of behavioral engineering. However, it failed for several reasons: It was too complicated for staff to implement, it required more resources (staff and time) than were available, the staff felt no ownership for the plan and felt it was unreasonable, and the critical problems at home and the mother's emotional problems were not addressed. The special education teacher expressed resentment regarding the "aversive" label and having to contend with a disruptive child who was not on an IEP. After the first week, her parents simply could not get Patty to school at all.

Systematic planning and team collaboration are essential in Blanco's (1982) comprehensive, multifaceted recommendations and in Want's (1983a, 1983b) "10-step common sense" approach. Want outlined the following treatment procedure:

1. Organize the school team.
2. Assess the family structure.
3. Develop a 5 day plan for returning the child to school with team cooperation.
4. Involve or neutralize the parents.

5. Require the more capable parent (or sibling) to bring the child to school or assign a team member to transport the child.
6. Prepare teachers for the child's return to school and plan appropriate responses to insure academic success and peer support.
7. Provide reality-based short-term counseling to child and parents at the school.
8. Limit child's complaints and do not reinforce panic attacks or make bargains.
9. Prohibit homebound instruction.
10. Encourage family therapy.

Team collaboration and planning are also essential in Heath's (1985) treatment recommendations:

1. Help the child to return to school and obtain relief at school rapidly.
2. Involve significant others in treatment implementation.
3. Intervention must be consistent and persistent.
4. Therapy, further evaluation, or placement may be necessary for chronic and pervasive maladjustment.

The school nurse alerted the school psychologist that Mary was missing too much school. The intervention team included the nurse, principal, teacher, and school psychologist. It was determined that the pattern of absences (every Monday and Friday, and after holidays), as well as the inadequate excuses (sore throat, headache) plus knowledge regarding the family (mildly schizophrenic father and marital conflict), probably indicated school phobia. There were no concerns regarding abuse or neglect. The father worked and the mother stayed at home all day with the younger children. Mary indicated to the teacher that she was "afraid something would happen to her mother" while she was at school. The mother felt it was unfair to expect Mary to attend school while ill but that she was not sick enough to see the pediatrician. The team's plan was for the school psychologist and nurse to call to schedule a home visit to inform the mother that:

1. *A physician would be required to excuse each absence (the team felt that this would soon become financially prohibitive for the family).*
2. *Unexcused absences would result in the notification of state child-protective services (this was a district policy).*
3. *The secretary was told to direct all calls from the mother to the principal.*

The threat of a home visit was sufficient to ensure the child's attendance. For the next 2 years, attendance always improved following requests for home visits.

Parent Involvement in Intervention Development and Implementation

As is evident in the procedure decision matrix (see Figure 2), the parents are consulted during the identification and evaluation process in order to determine etiology and influencing factors. Although the school psychologist or social worker is the most likely candidate, any team member experienced in effective interviewing techniques and who is knowledgeable about school phobia may be assigned to consult with the parents.

The purpose of the interview is two-fold: to determine factors within the family that are contributing to or maintaining the school phobic behavior and to determine whether there is a family member who will be able to facilitate the implementation of the treatment plan. Generally, children exhibiting more severe symptoms have parents who are less able to commit to intervention strategies (Want, 1983b). Additionally, the parent consultation may reveal factors influencing the parents' personality, emotional stability, communication skills , and level of understanding, which may affect their willingness or capability to cooperate with the treatment. On a cautionary note, the interviewer needs to be aware that there may be nothing within the family environment to blame for the school phobic behaviors.

Although it is desirable to encourage parent participation (Brown et al., 1974; Miller, 1972; Want, 1983a, 1983b, etc.), it is not always possible. If the parent or another family member (older sibling, grandparent, etc.) can-

not assist, they must be neutralized to prevent sabotage of the treatment plan. In that case, team members must be ready to control and implement the intervention plan. This may include assigning a team member to bring the child to school, delivering reinforcers, and performing other treatment strategies usually expected of the parents. Although the primary focus of the team will be on the child, there will still be a need to continue working with the parents, including referral to an outside agency for services if needed.

The team needs to provide information to the child's parents regarding school phobia and explain probable causative and maintaining factors. The treatment plan should be explained and parental involvement enlisted if possible. Language and terminology should be used that the parents can understand to decrease resistance and encourage commitment to the treatment plan. A treatment contract or some kind of written permission is recommended. Part of the intervention plan may include training in parenting or behavior management techniques. The involved parents will probably need considerable support and encouragement from the team. Parental denial or resistance should be dealt with in a nonthreatening manner. The interested reader is encouraged to read the literature on treatment compliance.

Key Elements for Treatment

Critical factors in determining effective interventions are listed in Table 8. Using these key elements during team discussions should facilitate the development of appropriate interventions.

Once intervention strategies have been determined, the team returns to the procedure decision matrix (see figure 2). The team has now agreed on etiology, has collaborated on treatment planning, team responsibilities have been assigned, and training has been completed. The implementation plan is implemented, monitored, and evaluated. Unsuccessful treatments should be modified or abandoned depending on the team's criteria. A successful treatment may be generally measured by school attendance data and, if possible, self-reports regarding a decrease in distress, depression, or other symptomatology.

After successful treatment, the team terminates the intervention. It is strongly recommended that the child be monitored for the next year or so. Transitions from elementary to middle school and from middle to high school may be especially prone to recurrence of the behavior.

Table 8

Key Elements to Consider When Developing Treatment Plans

Theoretical basis
- ☐ Etiology
- ☐ Treatment

Environmental influences
- ☐ School
- ☐ Community
- ☐ Home

Family influences
- ☐ Communication
- ☐ Relationships and alliances
- ☐ Parenting skills
- ☐ Family stressors
- ☐ Family history
- ☐ Ability to cooperate with treatment program
- ☐ Degree of commitment to treatment program

Internal factors
- ☐ Age and development of child
- ☐ Recent history
- ☐ Medical
- ☐ Severity and duration of symptoms

Team member involvement
- ☐ Membership
- ☐ Clear responsibilities for each member
- ☐ Need for agreement regarding etiology
- ☐ Need for collaboration in planning and implementation
- ☐ Training in intervention techniques

Other considerations
- ☐ Need for rapid, consistent, and persistent treatment
- ☐ Forced school attendance issues
- ☐ Ignore somatic complaints
- ☐ Encourage counseling for family

SUMMARY

The effectiveness of different available treatment techniques are uncertain because of the lack of adequate empirical study that does not have contaminated techniques (Trueman, 1984a, 1984b). The primary areas of agreement concern the need for rapid treatment and

ignoring groundless somatic complaints; however, this is far from sufficient in itself. The behavioral treatments would appear to hold the most promise and would be most easily implemented within the school setting. It should be apparent that the interventions developed should use strategies that the team is familiar with or that can be easily trained and understood. However, because of the need for rapid treatment, there is a definite need for guidelines to be used by school professionals.

Although the involvement of parents and significant others is most desirable, teams may need to neutralize them if treatment sabotage becomes apparent. Teams need to remain sensitive to the very real distress being experienced by the families of school phobics. Families who are currently unable to cooperate with intervention teams may improve with support or training. However, the intervention team may therefore need to be more responsible for implementation of treatment plans.

CHAPTER 5

CASE HISTORIES

Case History A: (No Intervention)

Adam was a 9-year-old boy who moved to the school district in December. His unmarried mother's current pregnancy was unplanned, and she openly communicated her intention to put the baby up for adoption. Adam's absences increased as her due date approached until he averaged four absences per week. Because Adam's mother was unemployed, and because she excused his absences, the school staff felt that she allowed him to stay home for companionship. When Adam was at school, he was socially withdrawn but academically capable. However, his absences and the resulting missed assignments and tests were causing him to fail. The teacher did not feel that interventions from the school psychologist were indicated because she felt that she could "handle" the situation on her own. Although Adam's situation was discussed in the teacher's lounge, no intervention occurred.

Following the birth and adoption, Adam's attendance improved, although he still missed either Mondays or Fridays. Absences were excused by the mother. Adam became very anxious, but the teacher did not ask for help until he began to regularly experience enuretic accidents at school. The principal went to the home, *and the mother* agreed to send Adam to school. He came to school the following day, but returned home to find his mother gone. She was *in jail for* writing bad checks. His attendance was excellent while he stayed with the neighbor, but after his mother returned home, Adam never came back to school. The family moved several weeks later.

This case emphasizes the need for school staff to quickly recognize that a problem exists and to ask for help in treatment. This particular teacher's "head in the sand" approach was caused by many reasons, including a belief that Adam would spontaneously improve. Although a very experienced teacher, she had never taught a child with school phobia. Additionally, she felt that asking for help equated with being a "poor" teacher.

Case History B: Intervention Using Special Education

Sam was a 7-year-old boy, and the youngest of three children. His father, a long-distance truck driver, was rarely home, and his alcoholic mother frequently left Sam in the care of his *older* siblings in the evenings. Sam was referred to the school psychologist in the first grade because of encopresis and symptoms of possible depression.

Sam's kindergarten *problems were* initially regarded by the teacher as simple separation anxiety, but his behavior and attendance deteriorated over time. At first, Sam's partings from his mother were characterized by both of them crying and Sam clinging to her when she attempted to leave. He *tried* to follow her out of the building, unless his teacher physically restrained him. Unfortunately, his mother would then circle the school building in her car. Sam, watching through the window, would then attempt to leave the building when he saw his mother. Because the situation was disruptive to the classroom as well as the school due to the screaming, crying, and general disturbance, the teacher began to allow Sam's mother to sit in the classroom with him. Sam's mother attended kindergarten for the remainder of the school year.

At the beginning of the next school year, Sam was frequently absent because of somatic complaints. The first grade teacher did not permit Sam's mother to bring him into the classroom but made arrangements to meet Sam and his mother at the school entrance. The first month of school was marked by Sam crying most of the morning and being passive and

socially withdrawn. Although he was able to do his assignments, he appeared to be very sad. At this point, he was absent approximately 1 day per week.

After 1 month, Sam became encopretic and enuretic at school. He never expressed any feelings of embarrassment, and he waited calmly for his mother to take him home. His "accidents" began to occur earlier in the day and were soon occurring daily. At this point, the school psychologist was contacted. The behavior problems that had occurred in kindergarten were not mentioned because no one had felt that they were related to the current situation and because it was assumed that the school psychologist was aware of the history.

Because the behavior appeared to be manipulative, it was recommended that a change of clothes be kept at school so that he would not have to go home following an "accident." Sam's mother was instructed to take him to a pediatrician, who could find no physical cause for the encopresis. Stool softeners were prescribed, but he began to soil several times a day. It was decided that an evaluation for special education was needed, because he was having difficulty learning math concepts and and now experiencing social problems because of the encopresis.

A comprehensive psychoeducational evaluation determined that Sam possessed average ability and near-grade-level skills. However, he was markedly immature socially and emotionally and appeared to be very depressed, dependent, and anxious. Much of his anxiety centered around his absent father and his physically aggressive brother. The brother, who was rebellious and hostile, could not be controlled by his alcoholic mother. The sister assumed parenting responsibilities and was Sam's "only friend."

Sam was placed in the classroom for students with behavior disorders in order to provide academic support and social skills training and to enhance his self-esteem. The encopresis stopped after 3 weeks in services, which included having several sets of clothes and making him clean himself up after "accidents." Sam's attendance improved, except for relapses following school holidays and legitimate absences for flu. The school psychologist and principal had instructed the mother to permit absences only if he had a temperature, vomiting, diarrhea, or other obvious indicators; however, she still required considerable support from the staff to cope with Sam's initial resistance to the program and for several problems throughout the year. Family therapy was recommended several times, but the father would not permit it, nor would he consult with the school psychologist.

The following school year, Sam was absent the first day of school, tardy the second day, and cried for the remainder of the week. The behavior disorders teacher and the school psychologist counseled the mother to provide support and encouragement, and Sam was provided with nondemanding, fun activities in his resource room period, which was moved to the first part of the day. By the third week of school, Sam appeared to have adjusted to school in a positive manner.

Sam did not exhibit unusually high rates of absences until he entered middle school. He missed the first week of school because of "flu" and was typically absent on Mondays and Fridays. An intervention team was called, and the school psychologist and principal met with the mother to offer support and to recommend outside counseling. Sam's attendance immediately improved, although the mother did not follow the recommendation for counseling. The second year of middle school began without absences until there was an accidental shooting in the home. While playing with a gun, Sam had accidentally shot his brother, who survived. The court ordered the family into counseling. At last report, Sam was in high school, still receiving resource room support and appeared to be functioning fairly well socially, *although* he still exhibits a higher rate of absenteeism than other students.

Although the outcome of this case was favorable, the late diagnosis and the lack of a comprehensive plan delayed treatment, which might have contributed to Sam's special education placement. Had a diagnosis been made rapidly, and a comprehensive, consistent treatment program implemented, Sam might not have suffered as much academic and social deterioration, and special education services might not have been needed.

This case illustrates the need for school personnel to recognize the characteristics of school phobia. Previous suspicious behavior

patterns need to be communicated to intervention teams and rapid treatment initiated before the behavior becomes reinforced. Lacking knowledge of the *kindergarten* behavior resulted in an incomplete picture of the dynamics causing the encopresis. The multidisciplinary evaluation process for special education delayed treatment, and although his attendance improved, the family dysfunction issues were not addressed until the gun accident. Although the special education and individualized attention helped Sam and his mother, he still is absent more frequently than the other students. The impact of being labelled "behavior disordered" will surely be long lasting.

Case History C: Using Decision Matrices

John was a 12-year-old student in the sixth grade. He was absent for 3 weeks in September and was consistently absent on Mondays and Fridays in October. Initially, the early absences were because of illness, but following recovery John stated that he was afraid to return to school. While at home, John's mother helped him with his homework, played games with him, and permitted him to watch TV and eat snacks. The school counselor alerted the school psychologist. The intervention team was organized, and it was decided that he was school phobic, based on the initial identification matrix and the information from the parent and child interviews.

John is an only child. His mother was unemployed and his father was frequently absent because of work. The team found that John's mother became anxious and overnurturing and that John became protective of his mother whenever his father was absent. John's social skills were seen as being weak, he was emotionally immature, and he lacked self-confidence. He had a history of allergies, migraine headaches, and hay fever. There had been less severe school phobia symptoms in previous years.

The intervention team determined that the contributory factors needed to be prioritized in order to decide what areas needed to be focused on for initial intervention. The evaluation and intervention decision matrix was used to decide that social skills training as well as making school a positive environment were the most important treatments. The school counselor trained John in social skills. An assignment sheet that emphasized a positive orientation was used. John's teacher helped him to make up the missed assignments and gave him considerable positive reinforcement for coming to school and completing assignments. Following initiation of the treatments, attendance was perfect.

The intervention team found that using decision matrices was most helpful in determining the etiology and types of appropriate interventions. They enabled treatment to proceed in a more comprehensive and organized manner than if no guidelines were available. According to the intervention team, the major difficulty in using the decision matrices was that in cases with multiple etiologies, subjective decisions were needed in order to prioritize treatment techniques.

Case History D: Using Decision Matrices

Mark was a 12-year-old in the sixth grade who had exhibited a pattern of absences since kindergarten, averaging 20 absences each year. Absences peaked in kindergarten (30 days) and in the fifth grade (29 days), and he had missed 11 days in the first month of the current school year. Mark's mother excused all absences for medical reasons, such as hives, vomiting, fever, sinusitis, viruses, and sinus headaches.

The intervention team determined that Mark's background contained numerous traumas, illnesses, and problems. He lived on an isolated farm with his mother. His father had been seriously ill and required a respirator for 5 years until his death when Mark was 8 years old. Two other family members died when Mark was 10 years old.

Mark was very fearful in kindergarten, and his pediatrician told Mark's mother to "just take him to school and leave him there." Although successful, Mark's mother began to take him to different physicians in order to acquire cures for his medical problems. She believed that all of his absences were caused by legitimate illness, and she was unaware that stress could cause physical symptoms. The team suspected that denial was also involved

because of the mother's reluctance to allow the team to contact Mark's current pediatrician.

Mark's mother had been self-employed as a babysitter, but she had quit because it "upset" Mark. However, she now needed employment due to financial reasons, which caused Mark to express concern about his mother not being at home.

When Mark was at school, he was quiet, participated in school activities, was on task, and performed well. Group testing indicated superior ability and above-average achievement. His social interactions were limited, but he was not socially isolated. He joined the basketball team but quit because "it made him get sick," and he also complained about his gym class.

The team found that the medical reports were inconclusive. Mark's diet was being manipulated in order to treat his headaches. The team educated the mother about the links between stress and the types of illnesses that Mark had exhibited. Biofeedback and relaxation training were implemented. Mark was encouraged to participate in intramural sports with physician approval. A Big Brother was assigned to Mark and counseling was conducted by the school counselor. After 6 weeks of treatment, Mark was rarely absent.

The intervention team found the decision matrices to be "very helpful" in collecting and organizing data. They clearly delineated the diagnostic procedures and facilitated the determination of needed interventions. The decision matrices provided opportunities for team discussions and decision making.

Case History E: Using Decision Matrices

The school nurse referred Ann to the middle school counselor because of concerns regarding recent absences. The nurse had heard Ann in the background yelling at her mother, "I'll never go back to school!" during a phone call to excuse the absence. The school intervention team included the nurse, counselor, assistant principal, and school psychologist. The counselor contacted the mother, who readily revealed that she was having terrible battles with Ann, who refused to attend school. It was decided that the school psychologist and the counselor conduct a home visit immediately because of the mother's growing hysteria. The mother and daughter were interviewed separately.

The mother denied the existence of family problems, but she admitted that this was "more than typical teenage problems." Ann's initial response was anger and refusal to cooperate. She claimed that she was too sick to go to school and that no one could force her to return. Eventually, it was determined that a classmate had teased her with the unwelcome information that Ann's father was having an affair and that "everybody" knew about it. Ann had confronted her father, who had initially denied it, but the affair was later proved to be true. Ann was primarily angry with her mother, whom she perceived as causing her father's affair. Ann was also angry with her father, but he was emotionally remote, and spent considerable time at work. The school intervention team decided that the school psychologist should meet with both parents simultaneously. The parents were given the explanation that Ann's refusal to attend school was partly to punish them but also because of embarrassment. The fact that she would now need to make up several big tests was also worrying her. Prompt treatment of the behavior, as well as family counseling, was recommended. The father initially refused the treatment plan on the basis that it was "none of the school's business," but before the intervention team could reconvene, Ann (on her own initiative) went to her father's office and announced that she would stay there to "keep an eye on him," and that she was "dropping out" of school.

Now in agreement that intervention was needed, the father was willing to cooperate with the team. The school psychologist arranged for immediate crisis counseling for the family at the local community mental health center. An intervention plan was developed to help Ann complete the missed assignments and tests over the weekend. Her father agreed to bring her to school 20 minutes early to meet with the school psychologist and she went to class with the understanding that she could visit the school counselor or psychologist if she felt stressed. She needed to see the school counselor several times that day and for the remainder of the week. The teachers were asked to be sensitive to any teasing or rumors. Although the family continued to experience significant

problems, Ann was no longer absent, except for legitimate illnesses. Ann's mother continued to contact the school psychologist for advice regarding Ann's rebellious behavior at home. The school intervention plan evolved into Ann making appointments to see the counselor or school psychologist when needed or "just to talk." The family remained in outside counseling. The transition to high school went smoothly, without recurrence of school phobic behaviors.

The success of this case illustrates the need for an alert and informed school staff member (in this case, the nurse) who immediately activates the team. The aggressive approach (going immediately to the home) facilitated rapid treatment, and the immediate team response toward plan development and implementation returned Ann to school rapidly before it became reinforced or escalated and masked the other family problems. Had Ann not forced the issue by going to her father's office, the intervention team would have needed to overcome the father's resistance or neutralized him (perhaps by empowering the mother) in order to attain rapid treatment.

Case History F: Preschool Intervention Using Decision Matrices

Mindy was brought to the early childhood special education screen. Her mother warned the screening team that 3-year-old Mindy would probably be uncooperative. Mindy refused all attempts to elicit compliance and clung to her mother, hiding her face. According to Mindy's mother, she had no developmental delays, except that she could not separate from her. She had been "forced" to attend bible school, but had not said a word and had hid in the corner for 3 months before the mother withdrew her. Mindy's mother had also attempted to take her to the library story hour, but Mindy had cried so loudly when her mother tried to separate that they had both been asked to leave. Mindy's mother wanted to enroll her in the special education preschool so that this worrisome "habit" would be eliminated.

The screening team referred Mindy to the school psychologist, who convened the intervention team. Using the decision matrices, it was decided that this was not a case of simple separation anxiety. Further conferences with the mother indicated a history of significant family and marital problems and that the mother was herself a very shy and withdrawn person. She also had knowingly left Mindy with a questionable babysitter the year before because she did not want to hurt the babysitter's feelings. The mother was now feeling guilt, and was panicked about current daycare and future kindergarten needs. At this point in time, Mindy could not be left with anyone except her grandparents, who were in the process of moving to another town.

Because of the extent of turmoil in the family and the mother's poor coping skills, the team decided that the first step was to refer Mindy and her mother for mental health counseling. Until Mindy's mother could help the team, it was going to be extremely difficult to provide treatment. Additionally, the team did not want the behavior to become even more reinforced. Working with the therapist, a plan was designed to gradually separate mother and daughter. Mindy and her mother came to the special education preschool for brief visits each day. Staff ignored her on the first two visits, then offered her treats when she arrived after that. The length of time for visits was slowly increased. Any behaviors that approximated contact with other children or staff were immediately rewarded. As these behaviors were shaped, Mindy's mother was asked to become more matter of fact while at school, and to pay her less attention, while staff were more attentive. Over time, Mindy's mother was gradually faded out of the classroom and out of the school. There were still problems about getting dressed, out of the car, and into the door. However, as soon as the mother left, Mindy was able to cheerfully participate in preschool activities. The mother required a tremendous amount of support and reassurance from the staff. She was shown a videotape to "prove" that Mindy could calm herself down following separation and that she played with other children and complied with staff requests. The videotape was highly effective in convincing the mother that the plan was effective and that she was "doing the right thing." Mindy's mother remained in much-needed therapy, although staff needed to periodically encourage her to continue.

Mindy continued to attend the integrated special education preschool until she became school aged. She willingly participated in kindergarten screening activities and, although she was tearful on the first day of school, so were several other children. Two years later, she has had no further difficulty with separation from her mother. She walks to school independently and goes to a babysitter after school. The school nurse will continue to monitor her attendance, and the middle school staff will be alerted to do the same after she makes the transition.

CHAPTER 6

PREVENTION AND RECOMMENDATIONS FOR TRAINING AND RESEARCH

Although school phobia occurs in only a small percentage of the population, its negative impact can be long-lasting if untreated. The literature has offered many explanations, and many treatments have been proposed. The consensus seems to be that to be effective, treatment needs to be initiated rapidly in a consistent and comprehensive manner.

The use of treatment guidelines and decision matrices has been shown to enhance the effectiveness of the school intervention team in the identification and treatment of school phobia (Paige, 1989, 1991). The provision of a readily available format enabled identification and rapid implementation of treatment, which is necessary for positive outcomes. Team collaboration is essential when planning and implementing intervention for school phobia, because it is rarely a "simple" problem but a complex of family, school, and internal factors. In some cases, special consideration is needed to prevent treatment sabotage.

The initial identification matrix has been highly praised by school intervention teams for its diagnostic clarity. The school intervention teams using the decision matrices felt they were very useful in initiating team discussions and decision making and in the collection and organization of data. The evaluation and intervention decision matrix was found to be useful for determining the etiology of the school phobic behavior, and the teams appreciated the flow within the matrix from diagnosis to recommended interventions.

A continuing concern is the typically lengthy delay between initial onset of school phobic behavior and the interventions. The children studied in these cases all had exhibited similar behaviors in the past, and it is clear that classroom teachers need to be educated about early identification of school phobia and the need for rapid intervention. Better communication is necessary among school staff members. In the case histories in this book, the school psychologist or school counselor was typically unaware that the child had experienced similar problems in the past. Certainly, all school intervention programs share these needs of education and enhancing communication, but it is strongly recommended that school phobia intervention programs incorporate training in these areas. Training programs for school psychologists, school social workers, and counselors should also include information regarding the diagnosis and treatment of school phobia despite the relatively small proportion of affected population. Although present in low numbers, children with these behaviors can be very distressing to teachers and parents, and if untreated, prognosis is generally poor.

Training school personnel in the early identification and the need for communication and rapid intervention should be developed as an integral part of a prevention program. Teachers, school attendance officers, and school nurses should be alert for patterns of continuous absences, particularly at the beginning of the school year and before and after holidays and weekends. Teachers should be encouraged to ask for assistance from support staff if a child is demonstrating significant separation difficulties or frequent absences. When a teacher refers a student who is highly fearful, anxious, or depressed or who is otherwise at risk, the consultant should also examine attendance records.

Early diagnosis and rapid treatment are critical factors determining good prognosis. Early childhood educators and daycare operators should be alert for unusually severe separation problems. Although separation problems are developmentally appropriate at certain ages, severe, prolonged, or unusual reactions warrant monitoring. A major obsta-

cle, however, is that the attempt to attend a preschool or daycare may be abandoned because of the child's or family's reaction. These children should be considered at risk because the reinforcement that may be associated with refusing to attend preschool or daycare may become generalized to later school attendance. Many of the children discussed in chapter 5 had experienced separation difficulties during the preschool years. Of those who had attended preschool or daycare, most either were rapidly withdrawn because of separation difficulties or had demonstrated significant distress at preschool, requiring considerable teacher attention. Of the latter group, the preschool teachers had all expressed concerns to the kindergarten teachers regarding the child's ability to adapt to kindergarten. Unfortunately, preschool "dropouts" are not consistently monitored, and this information is usually uncovered after the child is in school and is experiencing similar problems.

Information regarding at risk factors should be made available to early childhood educators, pediatricians, county health departments, and other children's health service providers. Kindergarten teachers, early elementary teachers, and guidance counselors need to be alert for children at risk for school phobia. Handouts, such as those found in Appendices A and D, may be helpful.

Students training in school psychology, school social work, and school guidance should be provided with sufficient information to raise their level of awareness regarding school phobic symptomatology and educate them of the need for a rapid, comprehensive treatment by the school team. These school professionals, more than any others, have the training and experience in consultation, problem-solving and group processes, and mental health skills needed for intervention.

Future research using the decision matrices should investigate their utility in various settings. It is also suggested that future research examine the effects of incorporating a prioritized decision tree for the selection of the most critical and immediate interventions. The question should be asked, "How will this effect decision making and program implementation?" More research will be necessary in order to adjust and redefine the treatment guidelines and decision matrices so that a comprehensive education, identification, and treatment program may be developed in order to provide prompt, comprehensive, and consistent treatment.

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APPENDIX A

WARNING SIGNS OF SCHOOL PHOBIA HANDOUT

Although the behavior called *school phobia* is rarely seen, it may cause long-term negative effects for children. Because the best predictor of successful treatment is early diagnosis, pediatricians, early childhood educators, and school staff need to be aware of the symptoms characterizing this disorder.

Although the child may not be afraid of school itself, complaints regarding difficult schoolwork and mean teachers or classmates are common. The child frequently complains of feeling ill, such as stomachaches, headaches, and the like. These complaints are presented to the teacher or parent in an effort to remain at home.

School phobia is often related to a fear of leaving home or the parent. This fear might have been accidently taught if the child returned home to find the parent unexpectedly absent, something "bad" might have happened at home while the child was at school, or the parent might have unintentionally communicated concerns regarding separation from the child. The child may be truly fearful or may be exploiting the situation.

Warning signs may include some or all of the following:

- ☐ Significant rate of continuous absences from school, particularly before or after weekends or holidays
- ☐ High levels of anxiety, fear, or panic attacks at school
- ☐ History includes significant separation difficulties
- ☐ Somatic complaints with no medical basis
- ☐ Presence of family dysfunction
- ☐ Lack of antisocial activities while absent
- ☐ Good grades prior to onset
- ☐ Child stays at home or in contact with parents
- ☐ Recent family stressors
- ☐ Child frequently resists attending school

Contact the school's intervention team, school psychologist, school social worker, or counselor for referral procedures.

APPENDIX B

SAMPLE STUDENT DATA SHEET

CHRONIC ABSENTEEISM REFERRAL

Name _____ Birthdate _____

Parent Name _____ Address _____

Home phone _____ Work phone _____

School _____ Teacher/grade _____

Reason for referral to school intervention team:

Attach copy of current and previous school attendance records and check:

_____ No. of days absent last year _____ No. of days absent this year

_____ Patterned absences (before or after weekends, holidays, etc.) If yes, describe:

_____ Absences are excused (by whom _____)

_____ Child stays at home or in contact with parent

_____ Child not home to babysit or supplement family income

_____ Child not engaged in antisocial activities

_____ Anxiety, depression, or fear present

_____ Somatic complaints

Summarize academic history in reading, math, written language (attach available testing data, grades, student samples):

TEACHER INTERVIEW

Describe the following:

Academic functioning:

Relationships with peers:

Relationship with teacher:

Student activities/involvement/extracurricular:

Other:

PARENT INTERVIEW

FAMILY DATA

Father _____ Age _____ Education _____ Employer_____

Mother _____ Age _____ Education _____ Employer_____

Sibling _____ Age _____ Education _____ Employer_____

Sibling _____ Age _____ Education _____ Employer_____

Sibling _____ Age _____ Education _____ Employer_____

Others living in home? _____

Only marriage? _____

Parent's perception of the problem:

Describe recent family stressors (recent death, illness, move, divorce, job change, dysfunctions, stability and communication patterns, etc.):

Previous adjustment or separation difficulties:

MEDICAL HISTORY

Describe child's previous hospitalizations or serious illnesses:

Age	*Description*	*# of Days Absent*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe child's current health:

Most recent medical exam and diagnosis:

Describe current antecedents, behavior, and consequences:

Team recommendations

Describe proposed intervention steps, timelines, and person(s) responsible:

Followup:

APPENDIX C

SUGGESTED RESOURCES

Consultation, Collaboration and Teaming

Bergan, J. R. (1977). *Behavioral consultation*. Columbus, OH: Charles E. Merrill.

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APPENDIX D

SAMPLE HANDOUT

SCHOOL PHOBIA

General Information

School phobia is an exaggerated and irrational fear of attending school. School phobia tends to be associated with anxiety, good grades prior to onset, school avoidance, continuous absences or patterns of absenteeism, and the parents' awareness of the absences and staying at home or in close contact with the child during absences.

Left untreated, school phobia may result in long-term deleterious effects such as multiple phobias, delayed learning, academic deterioration, the inability to establish meaningful peer relationships, adult mood disorders, and school or legal conflicts. Although present in only 2% of the school population, school phobia has been of great concern to educators, psychologists, and parents.

Although there is little agreement about the causes of school phobia, there are three major theoretical orientations: psychoanalytic, psychodynamic, and behavioral. Because treatment recommendations are generally associated with a particular theory, it is important for the intervention team to be in agreement regarding the etiology of a particular case, as well as in agreement regarding treatment. Because of differing etiologies, individual treatment programs must be developed on an individual basis.

Behavioral interventions are usually recommended for use by school personnel because of the objectivity, reliability, expediency, economic use of time and personnel, and the multidisciplinary approach. Behavioral techniques are usually in the repertoire of most school psychologists, and many schools have multidisciplinary teams on hand for purposes of special education preassessment and evaluation, student assistance teams, and the like.

There is little agreement regarding the "best" intervention because each case must be handled individually. Because school phobia affects only 2% of the population, appropriate intervention choices may not be readily available. Valuable time may be saved and prognosis improved if a general guideline is available.

Treatment Guidelines

1. To be effective, the intervention must be implemented soon after onset of school phobic behaviors. The greater the delay, the poorer the prognosis.
2. Somatic complaints (if they have no medical basis) should be minimized. This means that the school nurse and the family physician must be aware of the problem and strategies.
3. The issue of forced school attendance needs to be resolved by the team:

Pro	Con
Continual absences reinforce nonadaptive behavior.	Resultant stress of forced attendance compared with positive reinforcement techniques.
Continual absences result in impaired social functioning.	Forcible attendance may teach the child through modeling to ignore the feelings of others.
School may be the only consistent, stable influence.	
Child needs to recognize that the problem is not just at school.	

4. The intervention must be consistent and comprehensive.
5. Adults need to remember that the child, family, and teacher are feeling very stressed by these behaviors.

Decision matrices and related materials are attached in order to provide a treatment framework:

Procedure
Initial identification
Evaluation and intervention
Primary problems

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8455 Colesville Road, Suite 1000
Silver Spring, Maryland 20910

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